# Nebraska Health and Human Services System APPLICATION FOR ASSISTANCE



INSTRUCTIONS: Please read the entire application form including the Statements of Understanding beginning on page 11. Print your answers clearly. This becomes a valid application once you enter your name and address, sign the form and return it to your local Nebraska Department of Health and Human Services System (HHS) Office. You may have someone help you complete this form or you may contact the local HHS office for assistance. We may have to meet with you in order to process your application. If you need additional space, attach a separate sheet of paper and identify which question(s) you are answering. lf you are applying for the Food Stamp Program AND other programs, complete ALL fields &. If you are applying only for the Food Stamp Program, complete the fields marked with the logo &. WHAT KIND OF ASSISTANCE ARE YOU REQUESTING? Check all that apply: ☐ Money Utilities Medical ☐ Rent ☐ Other ☐ Food DOES ANYONE IN YOUR HOUSEHOLD NEED HELP WITH ANY OF THE FOLLOWING? Yes No Check all that apply: ☐ Child Care ☐ Reason for child care Provider ☐ Need Provider ☐ Home Care (Chores) ☐ Homemaker (Training) ☐ Meals Caregiver Support (Respite) ☐ Adult Day Care ☐ Transportation ☐ Other (please explain): Social Security No. (see pg. 13) First Name and Middle Initial Last Name Home Address/Directions to Your Home **₹** City **≥** State **₹** Zip Code **≥** City **₹** State Mailing Address (if different) **≥** Zip Code Home Phone Number Cell Phone/Pager Number Maiden Name or Previous Names Used Name and Phone Number of Emergency Contact OPTIONAL - Indicate the race of the head of household. Select all that apply. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure that benefits are distributed without regard to race, color or national origin. If you do not enter any information the worker will enter an answer to the race and ethnicity questions. ☐ American Indian or Alaska Native ☐ Asian ■ Black or African American ■ Native Hawaiian or Other Pacific Islander ■ White ☐ Other □ Do you also consider yourself Hispanic/Mexican American? □ Yes □ No COMPLETE THE FOLLOWING IF YOU HAVE AN EMERGENCY Do you have an eviction notice? Yes Have your utilities been shut off or do you have a shut off notice? ☐ Yes ☐ No Do you need immediate assistance with food? ☐ Yes ☐ No Do you have another kind of emergency which threatens your health or safety? 

Yes ■ No If yes, explain: \_\_\_\_ FOR OFFICE USE ONLY Received Date MC# Request Date ☐ Face to Face Mail Date Interview Date ☐ Phone

### NAMES OF ALL PEOPLE WHO LIVE WITH YOU

Complete this page for yourself and everyone who lives with you, even if they are not applying. If you are residing in a nursing home, boarding home or other group home, list only yourself and your spouse. Depending on the type of assistance you have requested, immigration status and Social Security Numbers (SSNs) may be verified.

Food Stamp Program: This application asks you to tell us about the citizenship and immigration status of people in your household. It also asks you to give us SSNs for everyone in the household. You are not required to provide this information. If some family or household members do not wish to apply for food stamp benefits, they do not need to provide their SSN or immigration status. If anyone in your household doesn't have an SSN, we can help them apply for one. Your application will not be delayed. We use SSNs to help us verify information such as income. We do not share SSNs with the Immigration and Naturalization Service (INS). For further information regarding how SSNs are used, see page 13. If people in your household choose not to give us information about their immigration status or SSN, their status will not be verified through INS or the Social Security Administration. They must still provide us the information needed to determine the eligibility of the other persons in your household. You may withdraw your request for food stamp benefits for these persons or you may withdraw your entire application.

<b>ৈ</b> NAME List Yourself First	Relationship to you. If not related write "NR"		è <b>●</b> rthda	te	∂ <b>a</b> Age	Sex Male (M) Female	ৈ <b>≗</b> Social Security Number	ls t per a U	son	ls t per	his son bled	pers	s this on eat	Marital Status
		Mo.	Day	Yr.		(F)		Υ	N	Υ	N	Υ	N	

1. Are you requesting assistance for anyone in your h		nt?	
Yes  No If yes, please provide the followin	g information:		
Name	Expected Date of Delive	ry	
2. Does anyone applying for or receiving assistance have	a guardian, conservator	, or individual actir	ng under power
of attorney?  Yes  No If yes, please provide	•		
Name of Guardian, Conservator, or Power of Attorney		Telephone Number	
		( )	_
Street Address	City	State	Zip Code
Whose Guardian, Conservator, or Power of Attorney is it?	Does Guardian/Conserv	ator expect payment fo	or his/her services?
•	l	f yes, amount	
	_		
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Child's Name	Noncus	stodial Parent's Name		Noncustodial Parent's Address		odial Parent's ecurity Number
3a. Please provide the following Noncustodial Parent's Name	Nonce	onal informationstodial rent's of Birth	No	ach noncustodial parent: encustodial Parent's Employer lame and Address	Name on E or P	odial Parent's Birth Certificate aternity wledged?
4a. 🏞 Is anyone in your hou				louing information.	·	
☐ Yes ☐ No Name	ii yes	s, piease provid		lowing information: e and Address of School		Grade
4b. 🏕 What is the highest gr	ade leve	l completed by	/ applica	ants 16 years and older?		
Name		Grade		Name		Grade
5 29 Diseas indicate very live			<u>'</u>			
5. Please indicate your live in a house - rent/ow Rent an apartment, duple Rent a room Board and room situation Adult Family Home Center for Development	n/mortga ex, triplex	ge x	00000	Assisted Living Nursing Home Drug abuse or alcohol treatment Battered spouse shelter Group home, foster care, child		· · · · · · · · · · · · · · · · · · ·
Live in a house - rent/ow Rent an apartment, dupl Rent a room Board and room situation Adult Family Home	n/mortga ex, triplex	ge x bled		Nursing Home Drug abuse or alcohol treatment Battered spouse shelter Group home, foster care, child		

6. Does anyone in your household age 20 or younger need a medical or dental examination?   Yes  No lfyes, please list name(s):
<b>NOTE:</b> Health Checkups: All persons age 20 or younger who are eligible for Medicaid are eligible for and encouraged to receive dental checkups every 6 months; medical checkups at 1, 2, 4, 6, 9, 12, 15 and 18 months of age, annually from ages 2 through 6, every 3 years from ages 7 through 10, and annually from ages 11 through 20. If you need help with transportation or scheduling an appointment, contact the local HHS office.
<ul> <li>7. In order to receive child care assistance, I agree to have my child(ren) immunized according to state immunization guidelines.  Yes No If you marked no, please circle the reason below.</li> <li>1. My religious beliefs do not allow immunization; or</li> <li>2. My child's medical condition would be harmed by immunization. (This requires a doctor's statement.)</li> </ul>
8. Who is your doctor?
WIC STATEMENT:  Nutrition Services: The WIC program provides nutrition information, breastfeeding support, healthy foods at no cost, and referrals to other health programs and community services and agencies. WIC serves women who are pregnant, breastfeeding or have recently had a baby, and children from birth to age 5. If you are interested, your local HHS office can tell you how to contact the local WIC agency in your area. You can reach the Nebraska WIC Office at 1-800-942-1171.
FOR OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE  Did you give the pamphlet explaining Health Check to the client?  Yes  No  Did the client understand the pamphlet?  No

N	Who	Amount	Financial Institution	Account Number

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(Food Stamp Program wit	raded or given away anything hin the past 3 months.) 🚨 Ye	s □ No Ifye	es, complete t		
Owner	Type of Pro	perty/Asset & Po	licy Number		Value
					\$
					\$
					\$
					\$
trucks, motorcycles, bo	d member's name appear on thats, RVs, snowmobiles, trailer yes, complete the following:	ne title of any lice s, etc.)	ensed or unli	censed vehic	les (include cars,
Owner	Type of Vehicle	Model	Year	Value	Amount Owed
				\$	\$
					\$
				\$	
				\$	\$
				\$	\$
				\$	\$
				\$	\$

ied Rece		Unearned Income Type	Paid To	How Much?	Claim Number
r Yes	No			How Often?	Address
		Social Security (RSDI)			
		SSI (Supplemental Security			
		Income)			
		Cash Assistance Payments:			
		ADC, AABD, RRP, Foster			
		Care, General Assistance			
		Veterans Benefits			
		Veterans Denents			
		Child Support/Alimony/			
		Spousal Support			
		State & County			
		Court Order No			
		State & County			
		Court Order No.			
		Unemployment Compensation			
		Dellar ad Defining			
		Railroad Retirement			
		Pension/Retirement/Civil			
		Service			
		Military Allotment			
+		Rental Income			
_		Contributions or Gifts/Money			
		from Friends or Relatives			
		Interest/Dividends/Annuities			
		Worker's Compensation			
		Worker's Compensation			
		Insurance/Accident Settlement			
		(Settlement paid in last 90 days			
		or is a claim pending?)			
		Claims/Disability Pay			
		Prizes/Awards/Winnings/Lottery			
		Striker Income			
		Indian Benefits			
		Trusts/Inheritances			

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3a. ₹ <b>3</b>		No	Graduate Assistantships, Fellowships, Stipends		Paid To	How Much? How Often?	Income is Intended to Cover	Expenses
3a. ₽								
	, Co		e for all who are cu ame		me and Address	Dates of	Hours per	Monthly Gros
					of Employer	Employment	Week	Income
							/week	\$
							/week	\$
							/week	\$
3b. 🍋	, Co				oyed in the last 90 da			T
		Na	ame	Nan	ne and Address of Employer	Dates of Employment	Hours per Week	Monthly Gros
							/week	\$
							/week	\$
							/week	
□ Y	⁄es	Ī 🔲 N		ousehold r	eceive tips, bonuse	s or incentive pay?		
	, <b>Ha</b> Yes				ob or reduced work	hours in the last 60	days?	
				F	FOR OFFICE USE ON	ILY		

	l who are currently self-employed	d or farming	g or who have	been self-emplo	yed or farming in
Name	Type of Employment and Name of Business	How Long?	Hours per Week	Monthly Gross Income	Monthly Business Expenses
			/week	\$	\$
			/week	\$	\$
			/week	\$	\$
DUR WORKER WILL EXP DIDENTIFY THE ALLOW I. Designation of " or households in which the or purposes of failure to e household member (incompany)	THESE COSTS CAN BE OBTAIN PLAIN WHICH OF THESE DOCUME VABLE COSTS OF DOING BUSING THE FOOLING BUSING THE FOOLING BUSING WITH WORK REQUIREMENTS, Cluding excluded members) who have the individual selected is work rents, the entire household may be	ENTS (TAX R ESS. d Stamp Protected which p the head of had the greatequirement	RETURN OR LI ogram: arent should I f household i itest amount o	EDGERS) YOU WI be considered the n households wit of earned income i	"Head of Household h no children must in the two months pri
ne "Head of Household" is		ICE USE ON	II Y		
	TOROTTI	ICE USE ON	<b>1</b>		

# 15. List the amount your household is currently billed for each of the following: (Food Stamp Program: Failure to report or verify an expense will be seen as a statement by your household that you do not want to receive a deduction for the unreported and/or unverified expense.) Current Expense Amount How Often Billed? Pays?

Current Expense	Amount	How Often Billed?	Who Pays?		
Rent/Mortgage (circle one)		Dilled:	ı ays:		
Name/address of landlord:					
Name/address of landiold.					
Is this public housing?    Yes    No					
Is this subsidized housing?  Yes  No					
If subsidized, what is your share of the rent?					
Lot Rent					
Hama Dranarty Tayon (not included in mortgage)					
Home Property Taxes (not included in mortgage)					
Homeowner's Insurance (not included in mortgage)					
riomeowner's insurance (normciaded irmortgage)					
Condominium Fees					
Condominarin ees					
Electricity					
Libertions					
Gas/Propane					
Guori Topulio					
Water/Sewer					
114.5.1, 05.115.					
Trash Collection					
Tradit delicotion					
Well/Septic Tank Maintenance					
Telephone (basic rate)					
,					
Child Support					
State & County					
Court Order No.					
State & County					
C					
Child or Adult Care					
Name/Address of Provider:					
Name/Address of Frovider					
Medical Expenses for persons age 60 or over or who					
are disabled. Include Medicare/health insurance					
premiums that you pay.					
Other (please explain)					
15a. 🍋 Does anyone outside your household pay	or halp nov any	of the chove even	2003		
Yes No If yes, please complete the		of the above expen	SCS:		
		/high avangage?			
Who:		vilicitexpenses?	· · · · · · · · · · · · · · · · · · ·		
Details:					
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16. Are you billed for a heating or cooling (air conditioning) expense separate from your rent /mortgage?						
☐ Yes ☐ No If yes, what is your primary source of heating/cooling? ☐ Electric/Heat ☐ Coal ☐ Kerosene ☐ Natural Gas						
☐ Electric/Teat ☐ Coal ☐ Refoserie ☐ Natural Gas						
Other (Ple						
Name/address of utili Name/address of utili					Λ	
Name/address of utili					Account	
16a. 🏖 If you answe	red NO to 16,					
apply.   Electricit					☐ Trash/Garbage Co	llection
16b. Has anyone i					Telephone  AP) for heating or coo	oling in the last 12
					our current address? [	
47 🔌 la anuana in usu					alth incomence Doblic	Haalth Camilaa
17.  Is anyone in you TRICARE, CHAMPUS					eaith insurance, Public	Health Service,
1	f yes, complete		_			
Names of	Policy			e Company	Policy/Group	Cost per
Insured Persons	Holder:		Name, Address	s, Phone Number:	Number:	Month:
						'
18. Does anyone in				verage?		
Yes No Person's Na			e following:	Perso	n's Name:	Medicare
1 013011 3 140			aim Number:			Claim Number:
(1)				(2)		
19. Does anyone in yo						
☐ Yes ☐ No	If yes cor	nplete tl	he following:	`	able to help pay these	e bills)
Person's Name				What months?		
20. Does anyone in you	ır household	have m	edical problem	⊥ s or medical cost	s due to an accident?	?
☐ Yes ☐ No			e following:			
Person's Name				Date of accider	nt	
21. Has anyone in your					the last 90 days:	
Yes No If yes, w	/ho			<u>-</u> .	State	
Caseworker's NamePhone No:						
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22.	Are you or any household member Yes No If yes, please list no					ation?		
23.	23. 🏕 Have you or any household member committed and been convicted of the following:							
	Violation		Yes/No	Who		When		
	a. Food stamp intentional program viola	tion?						
	b. Using or receiving food stamp benefi of a controlled substance?	ts in the <u>sale</u>						
	<ul> <li>Felony for <u>distribution</u> of illegal drugs August 22, 1996?</li> </ul>	after						
	d. Individual(s) in the household who ha more drug-related felony violations a possession or use of a controlled sul August 22, 1996?	nd convictions for ostance after						
	e. (1) Individual(s) in the household who than three drug-related felony violati for possession or use of a controlled	ons and convictions						
	August 22, 1996? (2) Individual(s) with drug-related felony for possession or use of a controlled substance after August 22, 1996							
	who are currently participating in or who has completed a substance abuse program since the last conviction?							
	f. Trafficking of food stamp benefits of	\$500 or more?						
g. Misrepresenting residency or identity in order to receive assistance or food stamp benefits in two or more states simultaneously?								
	h. Using or receiving food stamp benefits in exchange for firearms, ammunition or explosives?							
24.	24. Have you or any household member been disqualified from the Food Stamp Program?  Yes No If yes, who and what was the reason for the disqualification?							
25.		FOOD STAMP	PROGRAM					
	You can authorize someone outside your household to apply for you, obtain and use your food stamp benefits to buy food for you, or you can authorize one person to apply for you and another person to obtain and use your benefits to buy food for you.							
	Authorized Representative	Address		Telephone Number				
(1)								
(2)								
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### **Voter Registration**

Any citizen in the State of Nebraska who has met the voter registration requirements and applies for public assistance/food stamp benefits must be provided the opportunity to register to vote.

Yes	No	

If you are not registered to vote where you live now, would you like to apply to register to vote today? If you did not check either answer, you will be considered to have decided not to register to vote at this time.

Please note that the information and office to which application was made will remain confidential and be used only for voter registration purposes. Applying to register or declining to register to vote will not affect the amount of assistance or services that you will be provided by this agency.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the:

Nebraska Secretary of State, State Capitol Building, Lincoln, NE 68509-4608 Telephone: (402) 471-2554

If you would like help filling out the form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

### **Child Care Assistance**

Child Care Assistance is available only for approved activities such as work, employment related education or training, or Employment First activities. The family is responsible for paying the provider for any unapproved child care. Families responsible for paying a fee for child care services but who fail to pay the fee may have their child care case terminated.

# Nebraska Low Income Energy Assistance Program

When a household receives low income energy assistance (LIEAP), it must agree to take full responsibility for paying heating bills if the assistance payment comes directly to the household. If there is an overdue bill or poor payment history, the local HHS office is authorized to and may make payment directly to the provider on behalf of the household.

# **Child Support Enforcement**

Recipients of public assistance for minor children agree to receive Child Support Enforcement (CSE) services. Medicaid recipients, if not receiving other assistance, have the option to notify CSE that they do not want the services that are not related to securing medical support. Social security numbers of the child(ren) may be used for establishment and/or enforcement of financial and/or medical support.

Any legal action taken as a result of this application and referral to CSE is at the discretion of the county or authorized child support attorney. This attorney works solely on behalf of the State and an attorney-client relationship does not exist between the attorney and the applicant.

When ADC cash assistance is paid to an individual or family unit, the State has the right to receive and keep support payments due to any persons listed in the application for assistance. This assignment includes any support owed to the person at the time of application, as well as current and future support which may become due during the period that public assistance is provided. Support collected by CSE will be paid out according to State and Federal laws and rules. Any child/spousal/medical support payments received directly by an ADC recipient in the same month as ADC cash assistance must be reported and turned over to the State immediately.

When assistance is requested for minor children, it is a requirement to cooperate with ADC, AABD, Medicaid and CSE staff in all matters pertaining to paternity determination, location of noncustodial parent(s), and the establishment, enforcement, and/or modification of a support order. The exception to this cooperation requirement is a claim and establishment of a "good cause" exemption.

Individuals should contact their workers immediately at any time they believe that cooperation or proceeding to establish or secure support is against the best interest of the child(ren), parent/needy caretaker relative, and/or guardian/conservator for whom support is sought. Information to support the reason(s) for a good cause exemption will be requested.

### **Third Party Liability**

Individuals who receive Medicaid Assistance (Medicaid) must: assign to the State their right to any medical support or other payment for medical care; agree to cooperate with the State in establishing paternity; and cooperate with the State in obtaining any available third party payments such as an insurance payment or court settlement. Medicare benefits are not assigned.

Individuals must cooperate with HHS in obtaining reimbursement for the cost of medical care and services for any members of the assistance unit. Refusal to cooperate will result in the termination of medical assistance eligibility for that individual. The requirement to cooperate may be waived if HHS finds that refusal is caused by mental or physical infirmity, physical incapacity, or a reasonable likelihood of reprisal resulting in physical or emotional harm to any member of the assistance unit.

### **ADC Family Cap**

The needs of any child born more than 10 months after the application is signed will not be included in an ADC cash assistance payment.

### **Medical Records Release**

Upon request, any person who has medical records and information or the custody of such records regarding Medicaid recipients must release them to HHS.

### **Medical Reimbursement Agreement**

When the state pays for services for a Medicaid recipient, the amount the state has paid to treat the injury or illness must be included in any legal claim made against a third party. If the Medicaid recipient later receives an insurance or court settlement, HHS must be notified of the settlement and repaid from the settlement for the medical assistance the state has previously paid. Failure to reimburse HHS will result in termination of Medicaid eligibility for that individual.

# **Family Planning Services**

Family planning services including contraceptives or infertility services are available to all interested persons so that they may have freedom of choice in regard to the number of children in their family.

No one is required to accept family planning services to be eligible for assistance.

☐ Yes ☐ No Check the appropriate box to receive additional information.

### **Home Visits**

An HHS worker or contract agency representative:

- May conduct home visits to determine the appropriate types of assistance needed AND/OR
- May contact other people to verify eligibility for assistance.

### **ADC and Child Care Penalty Warning**

"Individuals who have knowingly provided false information in order to qualify for Aid to Dependent Children (ADC) or Child Care subsidy benefits may be subject to disqualification due to an Intentional Program Violation (IPV). For the Aid to Dependent Children (ADC) Program, only the individual found to have committed the IPV shall be disqualified. For the Child Care subsidy, the individual found to have committed the IPV and his/her family shall be disqualified. The period of disqualification shall be a) For a first violation, up to one year; b) For a second violation, up to two years; c) For a third violation, permanent disqualification. These penalties shall also be imposed if an individual is found by a Court to have violated Nebraska Revised Statutes, Sec. 68-1017."

# **Food Stamp Penalty Warning:**

The information provided on this application is subject to verification by federal, state and local officials. If any is found inaccurate, participation in the Food Stamp Program may be reduced, terminated or denied.

Individuals who have knowingly provided false information may be subject to criminal prosecution. Any member of a household who breaks any of these rules on purpose may be barred from the Food Stamp Program for 12 months for the first violation, 24 months for the second violation, and permanently for the third violation. Additionally individuals may be fined up to \$250,000, imprisoned for up to 20 years, and subject to prosecution under other applicable federal laws. A court can also bar an individual from the program for an additional 18 months. These penalties apply to food stamp household members as well as to retailers and others.

### DO NOT:

- Give false, incorrect, or incomplete information to obtain or continue to obtain food stamp benefits.
- Trade or sell food coupons or Electronic Benefit Transfer (EBT) cards.
- Use other people's food stamp benefits or EBT cards.
- Use food stamp benefits to buy ineligible items such as alcoholic drinks or tobacco.
- Use food stamp benefits to buy illegal drugs, firearms, ammunition, or explosives.

Individuals found guilty in federal, state, or local court of the following offenses will be disqualified from participating in the Food Stamp Program:

- Use of food stamp benefits in the sale of a controlled substance—disqualified for 24 months for the first violation, permanently for the second violation.
- Use of food stamp benefits to purchase firearms, ammunition, and explosives—permanently disqualified.
- Misrepresenting residency or identity in order to receive food stamp benefits in two or more states—disqualified for 10 years.
- Drug felony for distribution of a controlled substance committed and been convicted after August 22, 1996—permanently disqualified.
- Trafficking of food stamp benefits of \$500 or more—permanently disqualified.
- During the time an individual is fleeing to avoid prosecution, custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of the place from which the individual is fleeing, or is violating a condition of federal or state probation or parole, the individual is ineligible to participate in the Food Stamp Program.
- Comitted and been convicted of a drug felony for posession or use of a controlled stubstance IF the individual(s) has had three or more convictions for the possession or use, after August 22, 1996. .
  - If fewer than three convictions, is the individual(s) currently participating in or has s/he completed a state-licensed or a nationally accredited substance abuse treatment program since the date of the last conviction? If verification is provided of participation in and/or completion of the substance abuse program, the individual(s) may be eligible.

# **Work Registration**

For the Food Stamp Program, the signature of the head of household, other adult in the household, or an authorized representative on this application constitutes registering for work of all non-exempt household members.

# **Social Security Number**

HHS asks for Social Security Numbers (SSNs) of all individuals for whom assistance is requested as required by the federal Social Security and Food Stamp Acts. Individuals who are not applying for assistance for themselves are not required to have or provide an SSN. If the individual is financially responsible for others in the assistance unit, the SSN will be used only to verify income and/or resources through computer matches as listed below or other contacts so that eligibility can be determined for those requesting assistance. If the SSN is not provided, the assistance unit must assume responsibility for providing the information needed to determine eligibility for the individuals requesting assistance. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible participants. The SSN of each person in the assistance unit who provides his/her SSN will be computer matched with the following programs to assist in the determination of eligibility:

- Vital Statistics (Birth & Death)
  - —Nebraska HHS
- Unemployment Compensation
  - —Nebraska Department of Labor
- Employment
  - —Nebraska Department of Labor
  - —Social Security Administration
  - -Nebraska HHS

- Child Support
  - —Clerk of the District Court
  - —Child Support Payment Center
- Resources and Income
  - -Internal Revenue Service
- Social Security benefits (RSDI)
- Supplemental Security Income (SSI)
- Veterans' Benefits
  - —Veterans' Administration

The information received from these agencies is used and verified and could affect the kind and amount of assistance individuals receive. SSNs are also used in computer matching and program reviews or audits to make sure each household gets the correct amount of benefits. This may result in criminal or civil action or administrative claims against persons fraudulently participating. Child Care Assistance, Social Services for the Aged and Disabled (SSAD) and Social Services for Children and Families (SSCF): An SSN is not required to apply for these programs and eligibility will not be denied if SSNs are not provided. If an SSN is provided, it will be used to assemble research data sets that do not identify individuals and to verify income.

### **№** Food Stamp Program:

SSNs may be disclosed to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

If a household has a food stamp overpayment, the information on this application, including the SSNs, may be referred to federal and state agencies as well as private collection agencies for overpayment collection action.

Providing SSNs of household members is voluntary; however, failure to provide this information will result in the denial of food stamp benefits to any individual who does not provide or apply for an SSN.

### When this application is signed I agree that:

Under penalties of law and/or perjury, I declare I have read this application, including accompanying statements and to the best of my knowledge, the information is true, correct and complete. I understand my responsibilities and agree to fulfill them. I understand I may have to provide proof of what I have said. If written proofs are not available, I agree to give the name or organization so that the local office may obtain the necessary proof. I will cooperate fully with state and federal personnel in a Quality Control Review. I certify all persons for whom assistance is being requested are U.S. citizens or are in satisfactory immigration status according to the program(s) or services requested. I authorize the release of the SSNs provided on this application to HHS to use for the purposes mentioned above.

### Authorization for Release of Information:

I authorize the release of information requested by HHS. The requested information must be used solely in the administration of public assistance programs and will not be released to any other person or agency outside of HHS except as stated under the Medical Records Release. This release of information is in effect while I am an applicant or recipient of public assistance or a financially responsible member and for any later investigations pertaining to my eligibility and receipt of benefits. I understand HHS may release information to another agency when services of that agency have been requested or when the objective in obtaining the information is to provide services to me or to any member of the assistance unit.

### A reproduction of this release is as valid as the original.

Signature of Applicant		Signature of Other Adult Household Member			
Printed Name	Date	Printed Name	Date		
Signature of Witness if an "X" was used		Signature of Person who Hel	Signature of Person who Helped Authorized Representative		
Printed Name of Witness		Printed Name of Person who Helped Authorized Representativ			
Worker Conducting Interview	· · · · · · · · · · · · · · · · · · ·				

# IMPORTANT INFORMATION—KEEP THIS PAGE

### **YOU HAVE THE RIGHT TO:**

- Apply and discuss any action taken on your application or case with your worker or your worker's supervisor.
- Be assisted in the application process by the person of your choice.
- Referral to other private or public agencies.
- Examine your case record.
- See a copy of the program regulations.
- Have an interview in your home, at a mutually agreed upon location, or by telephone if <u>ALL</u> households members meet the following criteria:
  - Age 60 or older, or disabled AND
  - The household has no earned income.
- Reasonably prompt action on your application for benefits.
- Adequate notice of any action affecting your application or case.
- Have program requirements and benefits fully explained.
- Receive medical assistance (Medicaid) without a separate application if you are eligible for Aid to Dependent Children (ADC), Aid to Aged Blind and Disabled (AABD), or the Refugee Resettlement Program (RRP).
- Have your information treated confidentially.

### **Fair Hearings**

If you disagree with any action taken by HHS which affects your benefits you may request a fair hearing in writing or orally through the local office. You may continue to receive your current level of assistance until a hearing decision is made IF (1) you request a hearing within 10 days from the date of the agency notice, and (2) your certification period has not expired. A fair hearing request regarding the Food Stamp Program must be made within 90 days of the action or inaction. At the hearing you may represent yourself or be represented by another person.

### **Work Requirements**

If you receive Aid to Dependent Children (ADC) and/or food stamp benefits you must participate in approved work or work search activities unless you qualify for an exemption. If you do not fulfill work requirements, your benefits may be reduced or ended. ADC participants may be required to sign a self-sufficiency contract and service plan that lists the steps necessary to become self-sufficient.

# YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information. You may be subject to criminal penalties under applicable state or federal laws if you do not provide complete and accurate information. You are primarily responsible for providing proof of your household situation, but your worker will assist you in obtaining verification if you cooperate with the application process.
- Apply for and accept any potential benefits or income you may be eligible for if requested to do so by your worker. Does not apply to Food Stamps.
- Pay a co-pay for certain medical services if required to do so.
- Cooperate with state and federal personnel in a Quality Control review.
- Cooperate with Nebraska Managed Care Program for certain Medicaid recipients.
- Ask questions if you do not understand something about any program requirements.

## **Reporting Changes**

Report all changes within 10 days to your worker such as: ·

- Monthly income
- Household size
- A change in assets
- Household expenses
- Work status—including job training or other work activities
- Address
- Change in health insurance
- Change in disability or incapacity status.

The Food Stamp Program has different reporting requirements which will be explained to you by your worker.

### Medicaid

If you get any bills or statements from providers or collection agencies you are responsible to tell them right away your coverage is Nebraska Medicaid. If you don't, you may have to pay the bills.

- Ask your medical provider or worker about which services are covered.
- Present proof of your current Medicaid eligibility to medical providers before obtaining services.
- Inform your worker and your medical providers of any health insurance coverage you have (including dental coverage).
- Pay the cost of all non-covered medical expenses.
- Agree to enroll in employer-based group health insurance if HHS determines it is cost effective.

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Nebraska Department of Health and Human Services is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHSS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHSS Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHSS are equal opportunity providers and employers.

# FOOD STAMP REPORTING CATEGORIES

The Food Stamp Reporting Categories are listed below. The category you are assigned to tells you what your household is required to report during your certification period. When your household is assigned to one of these categories, your worker and/or eligibility notice will notify you of your household's reporting category.

# 1) SIX-MONTH REPORTING CATEGORY

Your household is required to report when your household's gross monthly income exceeds the maximum gross monthly income limit for your household size. Gross monthly income includes both earned and unearned income before any deductions, such as taxes. If your monthly income exceeds the maximum gross monthly income limit for your household size, you must report this within 10 days after the end of the month the income was received. Your notice of eligibility will tell you what the reportable gross monthly income level is for your household size.

# 2) TRANSITIONAL BENEFIT REPORTING CATEGORY

Your household is NOT required to report any changes.

# 3) CHANGE REPORTING CATEGORY

Your household must report changes within 10 days from the date the change becomes known to the household. Your household is required to report the following:

- 1. When anyone enters or leaves your household;
- 2. Proof of your new address and new shelter costs, if you move;
- 3. Receipt of additional vehicles;
- 4. Receipt of resources including cash on hand, stock, bonds, and money in a checking or savings account, whose total would bring the household over \$2000;
- 5. Changes in employment, in the wage rate, and in part-time or full-time employment status. These changes must be reported within 10 days of the date the first increase in income is received. For reporting purposes, 30 hours per week is considered full-time.
- 6. Changes in unearned income totaling \$50 or more per month received from non-private sources. These changes must be reported within 10 days of the date the first increase in income is received. You are NOT required to report changes in income from child support or alimony during your certification period.
- 7. Changes in the legal obligation to pay child support; and
- 8. Any change in work hours that brings an individual below 20 hours per week, averaged monthly for able-bodied adult without dependents (ABAWDs) subject to time-limited benefits.

Contact your worker if you have any questions about your reporting requirements.